

Sexual Health Quarterly Bulletin

Issue 15, March, 2007

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Department of Health Update by Steve Penfold

Implementing the 10 High Impact Changes for 48-hour GUM Access: Nobody said they were easy!

Open the 10 High Impact Changes (HICs), and you will find guidance on a whole range of aspects from measuring demand, through to better use of multi-disciplinary teams, and some clarity on cross-charging. Each one offers a section outlining what the change is; what are the benefits; "what do we need to do", and one or more case studies.

During National Support Team visits in recent weeks, we have found that most PCTs and Trusts have started to look at the HIC guidance and produced a summary on their progress. Whether they have looked at several, or all of the HICs, to date none has gone through the "who needs to do what" systematically.

To avoid this guidance being a missed opportunity, there are a few steps worth following.

- Bring commissioners and providers together to agree on what changes are the most important locally that will make the greatest difference to 48-hour access. Pick three or four to work through over the next few months.
- Agree a realistic plan with a timescale, decide who is responsible, what resources are required (and where they are coming from), and a completion date.
- Do try to quantify the outcomes from the changes. For instance, if releasing nursing staff to introduce symptomatic clinics, how many more patients does that mean the service can see per week?
- Do read carefully "what do we mean". For instance, don't get caught up trying to measure "un-met demand". Demand is only demand if it knocks at your door, so introduce a system of constant monitoring to respond regularly to

increases in demand. Un-met need is different, and requires a thorough needs assessment followed by appropriate commissioning of services.

- Do work through the "What do we need to do" thoroughly. Many of the actions will take time and some will require changes in working practice, which may need local negotiation.
- Remain "patient focused" throughout, particularly on difficult issues such as opening times.
- Prioritise and be proportionate; do not spend the next six months on something that may be helpful to patients, but probably will not be the critical factor as to whether you achieve 48-hour access.
- Once you have achieved your first few HICs, identify the next ones that will help you sustain the improvements, and go back to Step 2.

Finally, thanks for support from those areas that put forward emerging good practice for inclusion in the HIC guidance. Several North West case studies are included and now regularly feature when we are making our recommendations!

Payment by Results (PbR) for community sexual health services

From 15th March to 22nd June, the DH are consulting on expanding PbR to cover sexual health services other than GUM. Details are available from www.dh.gov.uk/en/Consultations

Implementing the 10 High Impact Changes for GUM conference, 22 May, Birmingham

For further details please see events section page 8.

Cheshire and Merseyside Sexual Health Network by Simon Henning

Following on from our last update we have been busy working on the Cheshire & Merseyside Business Plan for 2007/2008 and have secured commitment from PCT Chief Executives for funding for 2007/2008.

Development of the website www.cmshn.nhs.uk continues. We have completed the local Post Exposure Prophylaxis following Sexual Exposure to HIV (PEPSE) Guidelines which are being disseminated to colleagues in accident and emergency departments across Cheshire and Merseyside for local implementation. The Cheshire & Merseyside STI Care Pathway is now available for use and can be viewed on the website. If there is anything that you would like to see on the website, or feel we need to include, please contact the Network Administrator at terrol.evans@nhs.net

The Cheshire & Merseyside Network Board had a productive away day in January to review the aims of the Network, discuss progress to date

and look to the future and where we want to be in two years time. Key developments completed by the Network working groups include:

Training & Workforce Development: will be developing a strategy for the training and development needs for all staff involved in the delivery of clinical integrated sexual health services, looking particularly at: Nurses, working in different settings for example general practice nurses, school nurses; midwives; walk in centre nurses; community contraception nurses; GUM service nurses; health visitor nurses; Doctors; Others, for example pharmacists; youth workers.

Nursing Leads: The joint chairs of the working group and I recently presented at the Department of Health "Desire and Inspire" – Realising the Leadership Potential of Sexual Health Nurses" conferences in London and Birmingham which were very well received. The group

continue to develop leadership and share practice across the Cheshire and Merseyside area.

Reproductive Health: we have now completed the Service Standards Specification for Abortion Services within Cheshire & Merseyside, and are now focussing on late abortion provision; provision of LARC (Long Acting Reversible Contraception) post abortion and audit standards across Cheshire and Merseyside.

Media & Communication: we have now drafted the Media Protocol Guidelines for Cheshire & Merseyside and continue work on a framework for the implementation of effective sexual health promotion for C&MSHN.

For further information on the work of the Cheshire & Merseyside Sexual Health Network please contact:

Simon Henning, C&MSHN Co-ordinator simon.henning@nhs.net or Terrol Evans, C&MSHN Administrator, terrol.evans@nhs.net 0151 488 7775

Greater Manchester Sexual Health Network by Emma Thompson

New Lead Chief Executive for the Network

The Greater Manchester Sexual Health Network (GMSHN) has recently welcomed a new lead PCT Chief Executive; Laura Roberts from Manchester PCT. Laura has taken up this role after David King (Former North Manchester PCT Chief Executive) took the opportunity for early retirement at the end of last year. The GMSHN would like to express their thanks to David for his contribution to the Network.

Sector developments

The North East Sector (Bury, Oldham, Heywood, Middleton and Rochdale, and the North District of Manchester) has agreed a business case this includes additional sessions, a centralised booking for the four GUM clinics in the patch and capital investment in a new testing platform.

In the North West Sector; Salford have rolled out their new integrated hub and spoke model. The Tier 3 hub is being provided at the Oaklands Hospital (opposite the Hope Hospital

site) with 'spokes' providing a full range of sexual health services located across the city. Bolton have made a massive push towards the 48 hour access target reaching 81% in November's audit. Their Medfash visit is planned for 28th March. Ashton, Leigh and Wigan have increased the number of sessions being provided and the tender evaluation process is drawing to a close.

In the Central and South Sector, Manchester has had the business case for the Integrated Sexual Health Centre at the MRI approved by the Trust Boards. This exciting development would be operational in 12 months is now subject to NHS North West approval. Withington is due to have a Medfash visit on 27th March 2007. Tameside have made significant strides in achieving the 48 hour access moving to 77% in the latest audit.

Greater Manchester Chlamydia Screening Programme – RU Clear?

RU Clear was formally launched at three Network events across Greater

Manchester in February. The events were attended by nearly 300 Chlamydia Screening enthusiasts; download the presentations from www.RUclear.co.uk. To tie in with the launch RU Clear ran a media campaign with Key 103. Chlamydia screening adverts were run each evening in the run up to Valentine's day, supplemented by news items on the day (See page 3 for further details).

The Key 103 street team promoted Chlamydia screening in the town centres Bolton, Manchester, Rochdale, Oldham and Ashton Under-Lyne. Following the launch requests for postal tests have increased and website traffic is growing all the time with nearly 900 individuals accessing the site in February.

Current cumulative Screening figures to the end of February 2007 show that of the 5819 people screened, 656 tested positive for chlamydia, which is a 11.27% positive rate.

Cumbria & Lancashire Sexual Health Network by Stephen Woods

I have been in post as the Cumbria and Lancashire sexual health network co-ordinator for seven months now, six months of that has been full time. It has been a steep learning curve in many respects but never the less an interesting period. The re-organisation of PCTs has hindered progress in some areas, however things are beginning to settle down and the work is picking up pace. The task for the network steering group over the coming months will be to review the work to date and reconsider the established priorities.

A key area of development has been in the field of commissioning. A network-commissioning group has been established and has begun the task of pulling together a service model and associated specifications for the delivery of sexual health services. The group has been collecting examples of local, regional and national good practice and filtering this information to provide a comprehensive review of service developments.

The network has been successful in securing a small amount of funding to pursue this development and has employed an outside consultant to facilitate the first phase. The initial step along this road has already been taken in the form of a consultation workshop with

commissioners and public health colleagues from across the two counties to ascertain the support and appetite for collaborative commissioning.

The overall aim of the work outlined is:

To develop, agree and specify a service delivery model for sexual health services, covering all three tiers of service delivery, that can be applied across the two counties

Given the positive responses to the initial workshop referred to above, the next stage is to begin to develop service specifications that describe accurately the type of services that are required. These specifications will, in the first instance be aspirational in that they will describe the service delivery modal that commissioners will wish to move towards over the coming financial year. It is envisaged that after this time, service may well be placed out for competitive tender.

As part of this process we will aim to construct performance-monitoring frameworks, possibly using as templates those already in use in the substance misuse field. Other developments include supporting the development of a Lancashire wide sex and relationships policy and associated training programme. I have been working as part of a small

team to progress this work and we have secured funding from the Lancashire Teenage Pregnancy Partnership board to employ a training co-ordinator initially on a 12 months contract this post is now out to advert and the draft policy is nearing completion.

The network HIV subgroup has now reviewed its terms of reference and membership and has completed its draft action plan. The group is now in the process of defining its priorities for the next twelve months. The networks chlamydia sub group has been very active and has become an operational group. Activity has focussed around resolving issues in relation to the transport of laboratory samples and purchasing postal kits on a collaborative basis.

The network also supports the development work of the Lancashire Sexuality Equality Forum (LSEF) and the Navajo charter mark group. The Navajo chart mark is a certificate awarded to lesbian, gay, bisexual and transgender friendly agencies and organisations. The network is keen to support these developments across the wider Cumbria and Lancashire footprint.

For further information please contact Stephen Woods on 01253 651031.

The Valentine's Campaign by Josanne Cowell

Guess what you don't want for Valentine's Day?

The main aim of this campaign was to raise awareness amongst students about the sexually transmitted infection chlamydia, to encourage students to get tested and to promote safer sex. Greater Manchester has the largest student population in Europe and 1 in 10 people are currently testing positive for chlamydia.

The campaign ran over three days; the 12th, 13th and 14th of February and was based at the Manchester University Students Union on Oxford Rd. There was a team of approximately 50 students from

Manchester University, all wearing campaign T-shirts and handing out 5000 valentine's cards, with condoms attached, to young men and women aged 15-24 along Oxford Road. The cards provided information about chlamydia and where to get tested as well as encouraging the practice of safer sex.

Fifteen of the student team had also been trained up in the use of chlamydia testing kits by the Greater Manchester Chlamydia Screening Programme to use with students willing to be tested there and then.

At the same time there was a large mobile billboard with the valentine's image and message parked up close

by the students union which travelled slowly up and down Oxford Rd. To support the campaign there was also a full-page campaign message in the Big Issue the same week and local TV and radio coverage.

The Sexual Health Team at Manchester Public Health Development Service, the Greater Manchester Chlamydia Screening Programme and Peer Manchester (students from Manchester University) worked together on this campaign.

For further information please contact Josanne Cowell at josanne.cowell@manchester.nhs.uk

National Chlamydia Screening Programme in the North West by Pete Clark

The National Chlamydia Screening Programme (NCSP) is in its fourth year and third phase of implementation across England. There are ten programme areas within the North West Region (from Crewe to Carlisle) of which eight are currently delivering opportunistic chlamydia screening. The North West has played an integral part in the establishment of the NCSP. Since Wirral were involved in the pioneering pilot scheme in 1999. Wirral became the first Chlamydia Screening Office (CSO) in the North West, when the initial phase of the national programme commenced in 2003.

As the NCSP developed nationally, Wirral was joined by Liverpool, East Cheshire and West Cheshire during the phase two implementation in 2004. Since their involvement in the NCSP, Liverpool CSO have consistently delivered the highest number of chlamydia screens in the country, almost twice as many as the second highest programme area. As the national roll out reaches its culmination in 2006/07, North West phase three sites include Fylde Coast, Central Lancashire, Cumbria, East Lancashire and Greater Manchester. In their first quarter of operation Greater Manchester CSO achieved over 2500 screens, the second highest number of screens in the country.

By the end of December 2006, North West CSOs had delivered 21% of total national screens, resulting in 55,023 people accessing opportunistic chlamydia screening in the North West Region.

In addition to the high number of screens delivered in the region there is wealth of innovative work taking place. East Cheshire has developed an excellent model of working with secondary schools, and is one of the few areas in the country providing chlamydia screening in a school setting.

Central Lancashire is developing

work with partners in the community. The offer of a chlamydia screen is now standard practice within all community contraceptive clinics for people under 25 and the number of local GPs involved in the programme continues to increase.

Fylde coast (formally Blackpool) programme area, have established an inventive programme which enables people living in the rural community to access chlamydia screening, the programme includes screening events at the local agricultural college. East Lancashire is nearing the end of a pilot scheme, during which they worked with young people in five NHS and four non NHS settings. Evaluation of the pilot scheme will shape the future of chlamydia screening service delivery in the area.

It is widely acknowledged that the North West offers state of the art technology when it comes to laboratory facilities. The importance of the laboratories role in the NCSP can not be overstated. The first class service offered by many labs provide the CSO the opportunity to deliver a flexible service with confidence.

In May 2007, I will host the first North West Chlamydia Coordinators meeting. The event will provide CSO staff with an opportunity to identify common themes and share the good practice that is taking place the region. Additionally it will offer all staff a forum to discuss what works, and how they can optimise their screening programmes.

As part of the ongoing support, the National team will be offering a range of new services in the forthcoming months. The NCSP training pack will be available in April. The package aimed at developing existing services offers a range of training solutions that will assist CSOs and their partner organisations to maximise their contacts and raise their profile

throughout the local community. The pack includes specific modules that can be used with GPs and pharmacy staff who wish to play a prominent role in service delivery.

NCSP Website will be online by the summer. The site that will be primarily aimed at CSO staff and professionals, will contain up to date information on all aspects of the NCSP. It is also envisaged that the website will have a service user interface which will sign post potential service users to their local CSO. This element will be a major asset to those CSOs with their own website as a link will take users directly to your site.

There is continued work on the development of the national data base. This will allow CSOs to import their own data on to the national data base on a regular basis. A fail-safe facility will be included to prevent the importing of erroneous data. Once completed the database will also allow CSOs to extract their own data as and when required, in addition to the quarterly reports.

During my short time as NCSP Regional Facilitator, it has been encouraging to see the high level of dedication and enthusiasm amongst the eleven local coordinators and the wealth of expertise and knowledge from staff within CSOs across the North West. The implementation of the Primary Care Trust Local Delivery Plan targets has proved challenging for many chlamydia screening programmes. However, the work delivered in the North West continues to demonstrate innovation and success in its approaches to chlamydia screening and a positive point of reference for other programmes across England.

For further information please contact Pete Clark, North West Regional Facilitator (NSCP) at pete.clark@hpa.org.uk

Clinic in a Box by Susie Gardiner

Clinic in a Box is a health advice service for young people away from traditional clinic settings. They are a means of enabling young people to get advice at the point of need, and can be more accessible than other services as they are 'on the spot'. They have proved to be successful in schools and colleges throughout the country and from a sexual health aspect, they can offer: confidential advice and information; emergency contraception (EHC); condoms; chlamydia testing and pregnancy testing

Who can provide the clinic?

School Nurses are in an excellent position to provide the service. They do not have to be family planning trained as they can access emergency contraception training (probably from the local contraceptive service) and work to patient group directives. Likewise, they can utilise their local Chlamydia Screening Programme for training on testing and completion of relevant forms.

The school may already have a Nurse drop in service which can be expanded to include sexual health services. It may be that support staff are also needed, which could be a local youth worker, school health support worker or a Connexions personal adviser.

Again, the local contraceptive service can probably provide any short training that may be needed regarding condom demonstrations and pregnancy testing. It is important that the clinic is seen as separate from the school so that young people feel confident using the service. Although being on school site is invaluable, it is beneficial to keep some distance.

Who can advertise the clinic?

Assemblies or form meetings are a way of letting students know about the clinic. Personal social and health education (PSHE) classes can also be used to advertise the clinics and also discuss issues around teenage pregnancy and sexual health. If there are peer education programmes in the school, they can be a way of 'spreading the word' about the clinic. In addition, posters, flyers, stickers and credit card materials can market the service.

Having eye-catching publicity materials to advertise the service is vital - pupils can design a poster to advertise the clinic. This helps involve them and helps pupils to become familiar with the clinics.

National Targets and Policies

The National Sexual Health Strategy, the Teenage Pregnancy Strategy, Every Child Matters: Change for Children, the Government's Public Health White Paper, Choosing Health and the national Chlamydia screening programme all aim to improve the sexual health of young people. Clinic in a Box can clearly help to tackle these priorities as it improves access to confidential services that can have an impact on teenage pregnancy and sexual health, and referral opportunities. In addition, it can have an impact on other areas within the school as it can help strengthen the links with PSHE classes and sexual health.

Support for the programme

PCTs and Local Authorities need to work with schools, parents and Governors to ensure that clinics meet local needs. You may want to enlist the support of the Director of Children's Services and/or Director of Public Health. This will help to ensure that those working with children and young people are aware of the programme and understand their potential role within it.

It is important that the Head Teacher in each school is behind the programme as they can then help guide you through the processes to involve parents and/or Governors.

Confidentiality

You may want to think about who is providing the service and from where. This can have implications for confidentiality which will need to be confirmed to avoid confusion for both staff and young people as health professionals work to their own code of practice.

Young people may not feel confident accessing sexual health services, so it is worth considering making the clinic part of a wider health initiative, including information regarding other issues such as bullying, smoking

and emotional health.

Training

School Nurses and/or support staff will need relevant training, including EHC, pregnancy and chlamydia testing, and condom demonstrations. It may be useful for nurses and support staff to receive training together (excluding EHC training) so that staff can gain a full understanding of the capacity of other disciplines.

Referrals to other services

The clinic is also an excellent way of recording and tracking which services young people are referred to. This can help both the school and other agencies to gain knowledge about what services and/or information may need to be put in place, such as smoking cessation and diet/lifestyle.

"In the end, the clinic is an opportunity for young people, which is what we're aiming for," says Linda Thurlow, Deputy Head Teacher of Brookfield School in Kirkby.

Further information can be found at www.teachernet.gov.uk

Every Child Matters: change for children
www.everychildmatters.gov.uk

Accelerating the Strategy to 2010
www.dfes.gov.uk/teenagepregnancy

National Strategy for Sexual Health and HIV
www.dh.gov.uk

Choosing Health: making healthier choices easier
www.dh.gov.uk

Best practice guidance for doctors and health professionals on the provision of advice and treatment to young people under 16 on contraception, sexual and reproductive health www.dh.gov.uk

Teenage Pregnancy Strategy
www.dfes.gov.uk/teenagepregnancy

For any further information please contact Susie Gardiner at Susie.Gardiner@knowsley.nhs.uk

Asylum seekers and HIV by Jennifer Downing

Media allegation and sometimes popular opinion suggest that asylum seekers are health tourists who place a disproportionate burden upon health services, particularly when considering diseases such as HIV. In the UK health care services are available free of charge to asylum seekers however, asylum seekers face barriers to accessing care, can feel stigmatised by healthcare screening processes and can be reluctant to seek help. There is also a lack of information regarding the health and social needs of asylum seekers which hampers efforts to plan for their needs.

Currently no data on asylum seekers are collected in the United Kingdom. However, enhanced regional surveillance in the North West shows the proportion of individuals (in HIV treatment and care) increased from 3% (59/1964) in 2001 to 11% (408/3574) in 2004. Here we compare stage of disease and use of services between HIV positive non-asylum seekers and asylum seekers.

The enhanced regional surveillance system has collected longitudinal data on all individuals accessing hospitals and specialist non-governmental organisations (NGOs) annually since 1996. For this work the data were extracted from records of all HIV positive individuals accessing treatment and care services for the first time in the North West between January 2001 and June 2004 (2204 individuals, of whom 409 were asylum seekers). Sex, ethnicity, age, infection route, stage of HIV disease when first seen, access and use of

treatment and care services, and latest antiretroviral therapy regimen were compared. Independently, data were also collected from NGOs to establish which individuals had utilised these services. Following univariate comparisons, the variable clinic visit rate (square root transformed to improve normality) was entered as the dependent variable in a general linear model. Potential predictors and two-way interactions were removed in a stepwise manner until only significant terms remained. Logistic regression was carried out on ART and hospital stays.

Most asylum seekers were female (68%), infected via heterosexual sex (95%) and black African (95%). Univariate analyses revealed that asylum seekers were no more likely to enter treatment and care services at a later stage than non-asylum seekers and were no more likely to stay overnight in hospital (see table 1).

After multivariate adjustment ethnicity, not asylum seeker status, was a significant predictor of hospital admission. Analysis revealed that individuals from black and ethnic minority groups were significantly less likely to be admitted to hospital which may reflect service design issues or cultural differences around accessing care.

Asylum seekers had an average of one additional outpatient appointment per year than non-asylum seekers. Importantly, asylum seekers were much more likely to have accessed non-governmental organisations for care.

Empirical data on asylum seekers

accessing HIV treatment in the North West region identifies that stage of HIV disease when asylum seekers first access specialist services and their utilisation of such services is in general no different to HIV positive individuals who are not asylum seekers. This is contrary to anecdotal evidence and, with two thirds of asylum seekers first presenting with no symptoms, suggests that they may have been unaware of their status. This challenges the assertion that free treatment is their primary reason for entering the UK.

After controlling for asylum seeker status, stage of disease, route of infection and other demographic details, individuals from black and minority ethnic groups were significantly less likely to be admitted into hospital. Further research is required to identify whether this reflects service design issues or cultural differences around accessing care.

Asylum seekers accessed NGO care more than non-asylum seekers which shows their more complex social care needs. Paradoxically, asylum seekers rely more upon NGOs than other HIV positive individuals at a time when NGOs are under increasing financial pressures.

For published paper please see Treatment and Care of HIV Positive Asylum Seekers (Cook, et al., 2006) available from www.jech.bmj.com For further information please contact Jennifer Downing at j.downing1@ljmu.ac.uk

Table 1: Univariate (chi square) and multivariate (logistic regression) predictors of receiving antiretroviral therapy (ART) and being admitted to hospital for at least one night

	N	ART					Hospital admission				
		Univariate		Multivariate			Univariate		Multivariate		
		No	%	P	Adj OR (95% CI)	P	No	%	P	Adj OR (95% CI)	P
Sex				0		0.038			0.002		0.225
Male	1520	767	50.5		Ref		357	23.5		Ref	
Female	684	424	62		0.75 (0.57-0.98)		204	29.8		0.83 (0.61-1.12)	
Age				0		0.001			0.001		0.718
under 25	212	87	41		Ref		50	23.6		Ref	
25 to 39	1277	666	52.2		1.54 (1.11-2.13)	0.01	293	22.9		0.86 (0.58-1.26)	0.433
40+	715	438	61.3		1.94 (1.36-2.77)	0	218	30.5		0.9 (0.59-1.36)	0.606
Infection route				0		0.047			0		0.001
MSM	958	446	46.6		Ref		189	19.7		Ref	
Heterosexual	1025	630	61.5		1.42 (1.05-1.93)	0.024	295	28.8		1.59 (1.13-2.24)	0.008
Other/not known	221	115	52		0.96 (0.68-1.37)	0.832	77	34.8		1.96 (1.34-2.86)	0
Stage of disease				0		0			0		0
Asymptomatic	1392	584	42		Ref		191	13.7		Ref	
Symptomatic	415	324	78.1		4.93 (3.8-6.41)	0	136	32.8		3.05 (2.35-3.96)	0
AIDS	312	270	86.5		8.26 (5.83-11.72)	0	197	63.1		10.24 (7.69-13.63)	0
AIDS related death	30	6	20		0.3 (0.12-0.75)	0.01	28	93.3		95.1 (22.2-407.4)	0
Unknown*	55	7	12.7		0.21 (0.09-0.47)	0	9	16.4		1.37 (0.65-2.9)	0.405
Ethnicity				0		0.314			0.024		0.013
white	1248	628	50.3		Ref		311	24.9		Ref	
black	784	470	59.9		0.93 (0.68-1.28)	0.669	210	26.8		0.67 (0.48-0.95)	0.026
Asian subcontinent	50	31	62		1.51 (0.78-2.92)	0.219	19	38		1.14 (0.56-2.33)	0.71
other/mixed/NK	122	62	50.8		1.31 (0.85-2.02)	0.224	21	17.2		0.48 (0.28-0.85)	0.011
Asylum seeker status				0.001		0.096			0.716		0.412
Non AS	1795	939	52.3		Ref		454	25.3		Ref	
AS	409	252	61.6		1.29 (0.96-1.75)		107	26.2		1.15 (0.82-1.63)	

Teenage pregnancy rates in the North West

by Wendy Nicolson

The Office for National Statistics (ONS) released the latest conception data on 22nd February. The figures relate to 2005 and show teenage pregnancy rates overall are continuing to fall nationally. Nationally the rates have decreased by 11.8% clearly, the figures indicate that the strategy is pushing teenage pregnancy rates in the right direction - rates for under 18s are at their lowest level for 20 years indicating the historical trend is reversing. Unfortunately, progress in the North West is a disappointing, with only a 7.7% decrease from the 1998 baseline. Reductions in teenage conceptions rates vary across the region, with decreases of 26.9% and increases reaching 17.9%. Termination rates have remained fairly static.

We are concerned about the rates in the region, as we are committed to improving the quality of life of all young people. Therefore, we need to enhance the strategy and support local areas to move forward. There is still much we want to do and we have ambitious goals to reduce teenage pregnancy rates in our region and to ensure all local areas have a sustained downward trend which will translate into positive outcomes for young people.

The teenage pregnancy figures published on 22nd February relate to 2005, since then, there has been a major review of the Teenage Pregnancy Strategy and a detailed analysis of the performance of each local authority. As a result, each local authority has been required to re-examine its

approach, and incorporate the lessons from those areas achieving significantly falling rates. The 22 worst performing authorities in 2004 (four of which were from this region) attended a meeting with the Minister for Children, Beverley Hughes in January this year to reinforce the need to apply best practice rigorously everywhere and to ensure clearly strategic leadership in this area of work.

The figures show a wide variation in performance across the region in addition, this demonstrates how critical local delivery is. We know what works and local authorities and Primary Care Trusts have been given guidance regarding what works and the key ingredients for a successful strategy. All areas should be using this guidance to develop a strong action plan to bring down teenage pregnancies further.

The Strategy draws on the best available international research evidence. This has resulted in a multi-faceted approach, which includes helping young people resist pressure to have early sex through improved sex and relationship education (SRE) and supporting parents in talking to their children about these issues; increasing uptake of contraceptive advice by sexually active teenagers; and supporting young parents to improve the health and social outcomes for themselves and their children.

Local areas such as Oldham and Stockport in the North West are leading the field;

this is reflected in their falling teen conceptions. Both areas show just how much of an impact a good local plan can have on reducing the numbers of teenage pregnancies, and improving the life chances of young people in general.

We hope more local authorities will follow this downward trend. Government Office for the North West are working with local areas to improve performance and strengthen local delivery. We will be focusing on; targeted work with vulnerable young people, use of data and local intelligence, improving sex and relationship education, enhancing sexual health services, workforce development and raising awareness of the strategy across the region.

The recent regional conception data on under 18 conceptions and the England conception data on under 16 conceptions can be downloaded from the every child matters website www.everychildmatters.gov.uk

For further information please contact Wendy Nicolson, Regional Teenage Pregnancy Co-ordinator at Wendy.Nicolson@dh.gsi.gov.uk

Sexual Health Quarterly Bulletin

Written and edited by

Jennifer Downing -
Sexual Health Researcher

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Thanks are also due to Linda Thurlow

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News and events

Department of Health press release - Minister announces boost for gay men's health

Public Health Minister Caroline Flint announced on the 6th March that the Government is to fund a major study looking at why some gay men appear to be taking more risks with their sexual health in recent years. The results of the study will help the NHS and gay men's health organisations with their work to promote safer sex amongst the most at risk groups and assist with improvements to sexual health services for gay men.

The study will be a retrospective analysis of the extensive data collected over the past ten years from the annual Gay Men's Sex Survey (GMSS). It will examine all trends and changes during that time and look specifically at different groups of gay men that may be putting themselves at greater risk of HIV and other sexually transmitted infections (STIs). Caroline Flint was speaking at the 10th annual national CHAPS conference on gay men's HIV health promotion, organised by the Terrence Higgins Trust.

She said: "It is obviously a great concern that there is a persistently high number of HIV transmissions among gay men in the UK - at least 2,400 diagnoses in 2005. The challenge for the NHS and for others promoting gay men's health is how to address the diverse needs of those who have become sexually active in an age of effective HIV

Conference

Implementing the 10 High Impact Changes for GUM conference, 22 May, Birmingham

The National Support Team has block-booked a limited number of free places for the forthcoming Conventus conference on implementing the 10

treatments, and since the AIDS campaigns of the 1980s. We need to look at what is stopping some individuals from sustaining safer sexual behaviour. The new study we are funding will help us do this."

Will Nutland, Head of Health Promotion at the Terrence Higgins Trust said: "For the last decade, we've known that HIV and sexual ill health impacts differently on different groups of men who have sex with men. The new research funding will allow for detailed analysis of sexual behaviour of gay men and bisexual men across the last ten years and the findings will help to shape and inform future HIV health promotion programmes."

Peter Weatherburn, Director of Sigma Research, said: "This exciting new initiative enables us to re-visit and re-analyse 10 years of data, and re-present it online to commissioners and providers of HIV health promotion throughout England and Wales."

Ms. Flint also said that an extra one million pounds will be targeted this year at strengthening the Government's targeted HIV health promotion work for gay men and African communities.

She said: "I am pleased to say that this funding will continue next year and look forward to working with the Terrence Higgins Trust and CHAPS partners to decide the priorities for this additional funding for 2007/08."

HICs for those areas visited by the NST. To ensure some equity of access, the sexual health lead should coordinate a shortlist of those interested in attending, and liaise with the conference organisers (01926 863564) to check for availability.